

PRO determinations affecting Medicare Part A payment; and

(v) The charges for continued care will be invalid and refunded if collected by the hospital, to the extent that a finding is made that the beneficiary required continued care beyond the point indicated by the hospital.

(4) If the beneficiary remains in the hospital after the appropriate notification, and the hospital, the physician who concurred in the hospital determination on which the notice was based, or PRO subsequently finds that the beneficiary requires an acute level of inpatient hospital care, the hospital may not charge the beneficiary for continued care until the hospital once again determines that the beneficiary no longer requires inpatient care, secures concurrence, and notifies the beneficiary, as required in paragraphs (c)(1), (c)(2), and (c)(3) of this section.

(d) *Medically unnecessary diagnostic and therapeutic services.* A hospital may charge a beneficiary for diagnostic procedures and studies, and therapeutic procedures and courses of treatment (for example, experimental procedures) that are excluded from coverage under § 405.310(k) of this chapter (medically unnecessary items and services), even though the beneficiary requires continued inpatient hospital care, if those services are furnished after the beneficiary (or the person acting on his or her behalf) has acknowledged in writing that the hospital (acting directly or through its utilization review committee and with the concurrence of the intermediary) has informed him or her as follows:

(1) In the hospital's opinion, which has been agreed to by the intermediary, the services to be furnished are not considered reasonable and necessary under Medicare.

(2) Customary charges will be made if he or she receives the services.

(3) If the beneficiary receives the services, a formal determination on the validity of the hospital's finding is made by the intermediary and, to the extent that the decision requires the exercise of medical judgment, the PRO.

(4) The determination is appealable by the hospital, the attending physician, or the beneficiary under the appeals procedure that applies to deter-

minations affecting Medicare Part A payment.

(5) The charges for the services will be invalid and, to the extent collected, will be refunded by the hospital if the services are found to be covered by Medicare.

(e) *Services furnished on days when the individual is not entitled to Medicare Part A benefits or has exhausted the available benefits.* The hospital may charge the beneficiary its customary charges for noncovered items and services furnished on outlier days (as described in Subpart F of this part) for which payment is denied because the beneficiary is not entitled to Medicare Part A or his or her Medicare Part A benefits are exhausted. (1) If payment is considered for outlier days, the entire stay is reviewed and days up to the number of days in excess of the outlier threshold may be denied on the basis of non-entitlement to Part A or exhaustion of benefits. (2) In applying this rule, the latest days will be denied first.

(f) *Differential for private room or other luxury services.* The hospital may charge the beneficiary the customary charge differential for a private room or other luxury service that is more expensive than is medically required and is furnished for the personal comfort of the beneficiary at his or her request (or the request of the person acting on his or her behalf).

(g) *Review.* (1) The PRO or intermediary may review any cases in which the hospital advises the beneficiary (or the person acting on his or her behalf) of the noncoverage of the services in accordance with paragraph (c)(3) or (d) of this section.

(2) The hospital must identify such cases to the PRO or intermediary in accordance with HCFA instructions.

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 35688, Sept. 3, 1985; 54 FR 41747, Oct. 11, 1989; 57 FR 39821, Sept. 1, 1992]

**§ 412.44 Medical review requirements: Admissions and quality review.**

Beginning on November 15, 1984, a hospital must have an agreement with a PRO to have the PRO review, on an ongoing basis, the following:

(a) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges.

(b) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of §§ 412.82 and 412.84 of this chapter.

(c) The validity of the hospital's diagnostic and procedural information.

(d) The completeness, adequacy, and quality of the services furnished in the hospital.

(e) Other medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries.

[50 FR 15326, Apr. 17, 1985, as amended at 50 FR 35689, Sept. 3, 1985; 50 FR 41886, Oct. 16, 1985]

**§ 412.46 Medical review requirements: Physician acknowledgement.**

(a) *Basis.* Because payment under the prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's medical record, physicians must complete an acknowledgement statement to this effect.

(b) *Content of physician acknowledgement statement.* When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice:

Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

(c) *Completion of acknowledgement.* The acknowledgement must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient. Existing acknowledgements signed by physicians already on staff remain in effect

as long as the physician has admitting privileges at the hospital.

[60 FR 45847, Sept. 1, 1995]

**§ 412.48 Denial of payment as a result of admissions and quality review.**

(a) If HCFA determines, on the basis of information supplied by a PRO that a hospital has misrepresented admissions, discharges, or billing information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits under Part A, unnecessary multiple admissions of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, HCFA may as appropriate—

(1) Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided with respect to such an unnecessary admission or subsequent readmission of an individual; or

(2) Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(b) When payment with respect to admission of an individual patient is denied by a PRO under paragraph (a)(1) of this section, and liability is not waived in accordance with §§ 405.330 through 405.332 of this chapter, notice and appeals are provided under procedures established by HCFA to implement the provisions of section 1155 of the Act, Right to Hearing and Judicial Review.

(c) A determination under paragraph (a) of this section, if it is related to a pattern of inappropriate admissions and billing practices that has the effect of circumventing the prospective payment systems, is referred to the Department's Office of Inspector General, for handling in accordance with § 1001.301 of this title.

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 35688, 35689, Sept. 3, 1985; 51 FR 34787, Sept. 30, 1986; 57 FR 39821, Sept. 1, 1992]

**§ 412.50 Furnishing of inpatient hospital services directly or under arrangements.**

(a) The applicable payments made under the prospective payment systems, as described in subparts H and M of this part, are payment in full for all inpatient hospital services, as defined